

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0020910

1003

5055

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

JNF FILED 04 64 18

Primary Registration District No.

Registrar's No.

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH - a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Lemay</b>	
Length of stay in 1b <b>54 yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>726 Ruprecht Avenue</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>OTTO</b> Last <b>NOLL</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1964</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/30/1909</b>
9. AGE (last birthday) <b>54</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>grocer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Groc. &amp; Meat Market</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Daniel Noll</b>		13b. MOTHER'S MAIDEN NAME <b>Carolena Lindwedel</b>	
14. NAME OF HUSBAND OR WIFE <b>Ruth Wilson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>8</b>		17. INFORMANT Address <b>Mrs. Ruth Noll, 726 Ruprecht, Lemay, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC HEART DISEASE</b> web <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c) <b>ARTERIO SCLEROSIS</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b> <b>2 WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>DIABETES MELLITUS</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <b>4200</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>5/18/64</b> to <b>5/22/64</b> and last saw him alive on <b>5/22/64</b> Death occurred at <b>7:00 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>George A. Alama MD</b>	
22b. ADDRESS <b>6500 CHIPPEWA A AVE</b>		22c. DATE SIGNED <b>5/23/64</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>5/26/64</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Louis County, Missouri</b>		24. FUNERAL DIRECTOR ADDRESS <b>BEIDERWIEDEN F.H. INC., 3620 Chippewa St.</b>	
25. DATE RECD. BY LOCAL REG. <b>MAY 25 1964</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith. M.D.</b>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Dr. Daman  
6500 Chippewa St.

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 44520

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.